START-ODS
SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County’s Substance Use Disorder Organized Delivery System

HOMELESS SERVICES

April 5, 2018

Los Angeles County Department of Public Health
Substance Abuse Prevention and Control (SAPC)
SAPC’s Homeless Population
Homeless and Unstably Housed Patients

• 21.5% or 9,166 patients were homeless or unstably housed at admission in FY 15-16.

Living Arrangements Among Homeless Patients, FY 15-16

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Staying with family or friends (couch moving)</td>
<td>40.6%</td>
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<tr>
<td>Living outside</td>
<td>27.7%</td>
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<tr>
<td>Shelter or transitional housing</td>
<td>19.2%</td>
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<tr>
<td>Sleeping in car/van</td>
<td>4.5%</td>
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<tr>
<td>Using hotel/motel voucher</td>
<td>3.4%</td>
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<tr>
<td>Temporary indoor without services</td>
<td>1.4%</td>
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</tbody>
</table>

Note: Percentages are based on non-missing values, and may not sum to 100% due to rounding.
Homeless and Unstably Housed Patients

• 34.5% of patients who were homeless at admission were no longer homeless at discharge.

Trends in Housing Status at Discharge Among Homeless Patients, FY 15-16
Homeless and Unstably Housed Patients

- 38% patients reported having mental health issues, 22% medical problems, and 21% criminal justice involvement.
- 36% reported methamphetamine as their primary drug problem, followed by heroin (28%).
- 46% were treated in residential service programs, followed by outpatient programs (21%).
- 50% were discharged with positive compliance.
- 41% were Hispanic/Latino, followed by White (35%) and Black/African American (19%).
- 30% were age 26-34, followed by 35-44 (23%).
- 44% finished high school, followed by some high school (32%).
- 35% were unemployed and not seeking, followed by those seeking (23%).
Countywide Homeless Initiatives
County Homeless Initiatives

The Los Angeles (LA) County action plan to combat homelessness.

– On February 9, 2016, the Board of Supervisors approved 47 interconnected strategies focusing on homeless prevention, case management and services, subsidized housing, coordinated system, affordable housing, and increasing income

– SAPC leads the implementation of HI Strategy E2 on Drug Medi-Cal Organized Delivery System (DMC-ODS) for Substance Use Disorder (SUD) Treatment Services

– DPH serves as a collaborating partner in about 25 other HI strategies, including HI Strategy B7: Interim/Bridge Housing for those Exiting Institutions
Proposition HHH

LA City’s Permanent Supportive Housing (PSH) Loan Program to develop PSH for the homeless and those at risk of homelessness throughout LA.

– Passed by LA voters in November 2016, approving the 35 cents per square foot property tax
– Aimed at reducing homelessness by creating affordable housing units, and increasing accessibility to services
– Targets the creation of 10,000 affordable housing units for $1.2 billion over the span of 10 years
Measure H

The LA County quarter cent sales tax dedicated to fund programs that prevent and combat homelessness.

– Passed by County voters in March 2017
– Aimed at generating approximately $355 million annually over the next 10 years for homeless-related services
– Measure H Ordinance added 4 new HI strategies including D7: Provide Services and Rental Subsidies for PSH
– Supports 21 of the 51 HI strategies, including HI Strategy B7 and D7 for Recovery Bridge Housing (RBH), and Client Engagement Navigation Services (CENS) at PSH sites, respectively.
START-ODS Benefits
Focused on the Homeless and Unstably Housed
Increasing Access to Housing Options for Homeless Individuals with Substance Use Disorders

Glenda Pinney, MPH, JD and Elizabeth Norris-Walczak, PhD
Los Angeles County Department of Public Health, Substance Abuse Prevention and Control

BACKGROUND
Safe, stable and supportive living environments are essential to individuals recovering from substance use disorders (SUD). Patients with SUDs who are unstably housed or homeless are at greater risk of not completing treatment or relapsing. Beginning July 1, 2017, new services will be available under the System Transformation to Advance Recovery and Treatment (START-ODS) to help SUD providers link their clients to housing, such as Case Management and Recovery Bridge Housing.

RECOVERY BRIDGE HOUSING
Recovery Bridge Housing (RBH) is defined as a type of abstinence-based, peer-supported housing with concurrent treatment in outpatient (OP) intensive outpatient (IOP) or Opioid Treatment Program (OTP) settings. RBH is appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical and mental health conditions.

SAPC HOUSING GOALS
Improve housing access and linkages for homeless individuals receiving substance use disorder treatment.

OBJECTIVES
- Increase access to linkages to recovery housing, including recovery residences, for persons with substance use disorders.
  Timeframe: July 2017
- Train SUD treatment providers on how to complete the Vulnerability Index Service Prioritization and Decision Assistance Tool (VI-SPDAT) with homeless clients.
  Timeframe: June 2017
- Connect SUD treatment providers with the Coordinated Entry System (CES) to match their homeless clients to appropriate available housing.
  Timeframe: June 2017
- Develop a guide on housing options for homeless individuals, including bridge housing, transitional housing, recovery housing and permanent supportive housing.
  Timeframe: January 2017
- Organize a panel of housing providers to educate SUD treatment providers on housing options for homeless individuals with SUDs, including bridge housing, transitional housing, recovery housing and permanent supportive housing.
  Timeframe: October 2016

LINKAGES TO HOUSING
Clients seeking SUD treatment services will be assessed using the American Society of Addiction Medicine (ASAM) criteria. If, through the assessment, the client identifies as homeless, the assessor will refer the client to the SUD Case Manager for further assessment on housing, including Recovery Bridge Housing, and other service needs.

SUD Case Manager
assists the client in filling out the necessary application forms and collecting documentation (e.g., source of income, veteran status, substance use, identification papers, etc.).

CES Coordinators/Matchers implement and manage the administration of processing a match in the system. He or she monitors listings for available housing based on the client’s VI-SPDAT scores and housing preferences. SUD Case Manager is notified by the CES Housing Navigator when a Housing Provider is identified and has been notified of a match.

Once the necessary documentation is collected and entered into HMIS, the client is considered “Match Ready” and is eligible for permanent housing vacancies listed on CES.

SUD Case Manager coordinates appointments between the Housing Provider and the client; verifies eligibility information and assists the client with the housing application process.

CES Housing Navigator assists the SUD Case Manager with move-in resources for client (e.g., deposits, furnishings, etc.).

Source: Los Angeles Homeless Services Authority and Home for Good, an initiative of United Way of Greater Los Angeles and the L.A. Area Chamber of Commerce

CONTACT INFORMATION
For information regarding this poster, please contact:
Glenda Pinney, gpinney@ph.lacounty.gov, (626) 299-3571
Elizabeth Norris-Walczak, enorris@ph.lacounty.gov, (626) 299-3570
# HMIS Access and CES Referral

## Providers with HMIS Access

- 19
- SUD Case Manager\(^1\) conducts the CES Survey Packet for Adults including VI-SPDAT, or Next Step Tool for Youth\(^2\)
- SUD Case Manager enters or updates information into Homeless Management Information System (HMIS)\(^3\)
- SUD Case Manager advises the CES agency that patient information has been entered into HMIS

## Providers without HMIS Access

- 59
- SUD Case Manager links the patient to CES/housing agencies

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1. At minimum registered-level SUD Counselor  
2. Training required  
3. Active user license and training required
Case Management

Connection

• Conducting housing assessments (e.g., CES Survey Packet for Adults including VI-SPDAT, and Next Step Tool for Youth)

• Referring patients to housing and homeless service agencies; including the lead CES providers for youth, adult, or families (211)

• Assisting patients with gathering necessary documentation, and completing housing application forms
Case Management

Coordination

• Identifying an RBH provider through the Service and Bed Availability Tool (SBAT), and scheduling an appointment for RBH placement

• Sending RBH providers the necessary re/authorization documentation

• Advising the CES Housing Navigator that a patient’s information has been entered into HMIS, and verifying whether or not all necessary forms and documents have been uploaded into HMIS

• Scheduling appointments between the patient and the Housing Provider

• Working with the CES Housing Navigators on move-in resources
Case Management

Communication

• Updating the RBH and other Housing Providers of patients’ treatment status
• Entering and updating information into HMIS
• Following up with the CES agencies about the status of matching the patients to housing
• Educating the patient on landlord-tenant responsibilities, budgeting, and life skills
Recovery Bridge Housing

A type of abstinence-based housing that provides a safe interim living environment for SAPC patients, including those in Medications for Assisted Treatment (MAT).

Eligibility Criteria:  
- ☑ 18 years or older  
- ☑ Homeless or unstably housed  
- ☑ Concurrently enrolled in Outpatient, Intensive Outpatient, Outpatient Withdrawal Management, or Opioid Treatment Program

Length of Stay:  
- Up to 180 days for general patients, and up to 60 days postpartum for perinatal patients

Capacity:  
- 750 beds for the initial year, FY 2017-18
Recovery Bridge Housing

**Funding Support:**
- Measure H for those exiting institutions
- Other applicable SAPC funding sources

**Referral Process:**
- Clients are referred for SUD assessment.
- If client meets criteria for OP/IOP/OP-WM/OTP treatment and for RBH, the SUD provider then initiates the referral to an RBH provider.

**Tx Provider Roles:**
- Refer patients to RBH.
- CES housing assessment and/or refer patients to housing resources at the beginning of treatment.
Recovery Bridge Housing

Tx Provider Roles (cont.)

☑️ Send RBH providers proof of treatment enrollment, indication of homeless status and need for RBH in the Treatment Plan, and other required re/authorization documentation.

☑️ Updating RBH providers if patient has been discharged from treatment.

☑️ Document coordination with RBH providers in Sage Miscellaneous Notes.

☑️ Complete CalOMS/LACPRS.

☑️ If also an RBH provider, refrain from restricting RBH beds to only the providers’ patients.

References:  
- RBH Bulletin  
- Provider Manual 3.0  
- Checklists: Sage and Manual versions
Client Engagement and Navigation Services

Permanent Supportive Housing Sites
• SUD screening, referral, and service navigation to residents at project-based PSH housing throughout Los Angeles County
• Funded by Measure H under Homeless Initiative Strategy D7

Homeless Outreach
• Street outreach, engagement, screening, referral, and navigation services to homeless individuals in Venice, Spring Street, around Harbor-UCLA Medical Center, and at the Pomona Armory Shelter
Homeless Programs
Next Steps
HMIS License Issuance

☑ Adult Providers: Goal to provide each one with HMIS license

☑ Youth Providers: Topic to be discussed at the next Youth Provider Network Meeting

☑ SAPC to gather HMIS users information from providers

☑ Providers to submit HMIS **Organizational** Agreement to LAHSA

☑ At minimum SUD Registered Counselor to submit the HMIS **User** Agreement to LAHSA

☑ Required Trainings
  - CES Overview
  - CES Survey Packet for Adults and/or Next Step for Youth
  - HMIS Policy
  - HMIS for Adult and/or Youth Systems
Trainings

SUD Provider Capacity Building

☑️ System Overview and Assessment Tools: CES Overview; CES Survey Packet (including VI-SPDAT) for Adults; CES Next Step Tool for Youth

☑️ Database: HMIS Policy; HMIS for Adult and/or Youth Systems

☑️ Data Collection: CalOMS/LACPRS Homeless-Related Items

☑️ Service Skills: Cultural Competency

☑️ Housing Resources and Partners: Supportive Housing, Harm Reduction, CES Partners

SUD Referral Pathways

☑️ START-ODS Benefits and Referrals Webinar to CES Agencies
Homeless Provider Network

- Network launch, and subsequent regular meetings
- SBAT Homeless Provider list
## Timeline

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<th>April</th>
<th>May</th>
<th>June</th>
<th>FY 18-19</th>
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Homeless Data Collection
Why Data is Important?

• Data is a critical resource of value-based managed care program:
  – Track and forecast utilization, revenue, and cost
  – Demonstrate effectiveness/outcomes
  – Inform and enhance business, policy, and operational decisions in managing costs, quality of care, and revenue.
• “What gets measured, gets managed”
  – Peter Drucker
Cal-OMS/LACPRS Homeless-Related Items

https://lasapcpconnuat.netsmartcloud.com/pcsbox/
THANK YOU

For more information, contact:

Glenda Pinney, Kristine Glaze
Adult Systems of Care
SAPC_ASOC@ph.lacounty.gov

Tina Kim
Health Outcomes and Data Analytics
tkim@ph.lacounty.gov

SAPC Website:  www.publichealth.lacounty.gov/sapc